SOCIAL SERVICES BLOCK GRANT

State Form 48203 (2-97) / DHHS 0002

Mail to:
Deaf and Hard of Hearing Services
Family and Social Services Administration
Division of Disability, Aging, and Rehabilitative Services
P.O. Box 7083
Indianapolis, IN 46207-7083

Service authorization number

Name of vendor

Name of agency / firm / organization	Name of requestor	Telephone number

Address of requestor (*number and street, city, state, ZIP code*)

Name of consumer(s)	Situation

Service date	Date requested	Date confirmed

Requested service time	Actual service time	Total service time
☐ A.M. ☐ P.M. to ☐ A.M. ☐ P.M.	☐ A.M. ☐ P.M. to ☐ A.M. ☐ P.M.	

Site of service address (*number and street, city, state, ZIP code*)

Travel from	Travel to	Total miles (*round trip*)

Type of service	Name of interpreter(s) or case worker
☐ Interpreting ☐ Case management	

County of service

Signature of authorized vendor representative	Title	Date (*month, day, year*)

Administrative instructions or explanations

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